Emergency

EMERGENCY ROOM OUTPATIENT SERVICES TRAINING PACKET

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Updated payment system for Emergency Room services to reflect new policy for outpatient hospital provider type 01.

EFFECTIVE SEPTEMBER 1, 2002

1. **ER rates for provider types 01, current type of bill 131 (UB92). To be paid as "fee for service," with flat rate billed with two revenue codes 450 and 451 reflecting levels of service. These revenue codes are to be inclusive of the majority of services with a few exceptions.**

2. **Revenue codes 450 must be billed with one of the following, if not the claim should deny.**

CPT code 99281 = Level 1
CPT codes 99282 & 99283 = Level 2
CPT codes 99284, 99285, 99291 & 99292 = Level 3

3. **Revenue Code 450:**
If the following revenue codes are billed with revenue code 450 then payment would be only from amount determined due for revenue code 450 and appropriate CPT code.

Lab	300, 301, 302, 303, 304, 305, 306, 307, 310, 311, 312, 314, 380, 381, 382, 383, 384, 385, 386, 387, 390, 391, 923, 924, 925
X-Ray	320, 321, 322, 323, 324, 330, 342, 400, 403, 920
Supplies	270, 271, 272, 274, 275, 621, 622, 623
Pharmacy	250, 251, 252, 254, 255, 258, 260, 261, 634, 635, 636
EKG/ECG Therapeutic Services	410, 412, 413, 420, 421, 422, 423, 424, 440, 441, 442, 443, 444, 460, 470, 471, 472, 480, 482, 510, 512, 516, 517, 730, 731, 732, 740, 901, 922, 940, 942, 943
Rooms & Miscellaneous	280, 290, 370, 371, 372, 374, 700, 710, 750, 761, 890, 891, 892, 893, 921

No Revenue Code 450:
If the above revenue codes were not billed with revenue code 450, then payment for these departments would be based on Medicaid's current reimbursement method.

Revenue Code 451: TRIAGE
Shall not be billed in conjunction with any other revenue code.

Professional Component: FOR ER ONLY
Payment for professional component should now be submitted on a HCFA 1500 beginning September 1, 2002. The following revenue codes should not be billed on a UB92; Revenue codes 963, 971, 972, 973, 974, 981, 985 and 986.

EFFECTIVE SEPTEMBER 1, 2002

The following revenue codes will be paid as a flat rate if performed as part of the emergency room service (450). You will also be reimbursed for the emergency room charge.

CT Scans; Revenue Codes 350, 351 and 352:
Payment will be lesser of flat rate or billed charges.

Ultra Sounds; Revenue Code 402:
Payment will be lesser of flat rate or billed charges.

Cardiac Cath Lab; Revenue Code 481:
Payment will be lesser of flat rate or billed charges.

You must use one of the following CPT codes to indicate left, right or bilateral.

- **CPT codes for left or right are 93501 to 93505, 93510, 93514 and 93530.**
- **CPT codes for both sides are 93511, 93524 to 93529, 93531 to 93533.**

MRI; Revenue Codes 610, 611 and 612:
Payment will be lesser of flat rate or billed charges.

Observation Room; Revenue Code 762:
Payment will be lesser of flat rate or billed charges.
One unit must equal 23 hours or less observation. Payment will be made for only one.

Lithotripsy; Revenue Code 790:
Payment will be lesser of flat rate or billed charges.

CLAIM EXAMPLE 1

Revenue Code 451 (Triage) can not be billed in conjunction with any other revenue codes. See claim example.

******* PLEASE NOTE THAT THE CHARGES ON THE CLAIM MUST BE THE USUAL AND CUSTOMARY CHARGE.**

ub-92 claim form

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
1-800-111-222 USA HOSPITAL 999 PARKVIEW AVE ANYTOWN, KY 40001		234GTA567	131

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	9/1/02	9/1/02					

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
			9/1/02	00				30									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
451	TRIAGE			1	$20.00		
001	TOTAL CHARGES				$20.00		

50 PAYER	51 PROVIDER NO.	52 REL. ASG. INFO BEN	53	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
KY MEDICAID	01223377					

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Nora Ward		4013446688		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
450	7890								450		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID
56732 Juanita Wolf

83 OTHER PHYS. ID
A

OTHER PHYS. ID
B

84 REMARKS

85 PROVIDER REPRESENTATIVE
Hand Written Signature
X

86 DATE
9/1/02

UB-92 HCFA-1450 OCR ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A

CLAIM EXAMPLE 2

When billing a revenue code for 450, you must also use a CPT code to determine the level of care. The Emergency Room Service will be paid as a flat rate. When billing one of the following revenue codes listed on page 6 this training packet, you will be paid a flat rate for the service provided as well as the fee for the 450 revenue code. See claim example.

****** PLEASE NOTE THAT THE CHARGES ON THE CLAIM MUST BE THE USUAL AND CUSTOMARY CHARGE.**

1-800-111-222
USA HOSPITAL
999 PARKVIEW AVE
ANYTOWN, KY 40001

1

2

3 PATIENT CONTROL NO.: 234GTA567

4 TYPE OF BILL: 131

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	9/1/02	9/1/02					

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
			9/1/02	00				30									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
350	CT SCAN			1	$500.00		
450	EMERGENCY ROOM	99281		1	$70.00		
480	CARDIOLOGY			1	$900.00		
001	TOTAL CHARGE				$1,470		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
KY MEDICAID	01223377					

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P. REL	60 CERT -SSN-HIC -ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Nora Ward		4013446688		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
450	7890								450		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS.ID: 56732 Juanita Wolf

83 OTHER PHYS. ID
A

OTHER PHYS. ID
B

84 REMARKS

85 PROVIDER REPRESENTATIVE: **Hand Written Signature** X

86 DATE: 9/1/02

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF..

CLAIM EXAMPLE 3

EFFECTIVE WITH THE IMPLEMENTATION OF DRG

Emergency room services within 24 hours of admission is to be billed on an inpatient claim and paid inpatient rate. The days on the inpatient bill must show only the days of the inpatient stay. The admission date does not change if the emergency room service was for the day prior to admission.

Emergency room services billed for the same date of service as previously paid claims for an inpatient service should be considered duplicate.

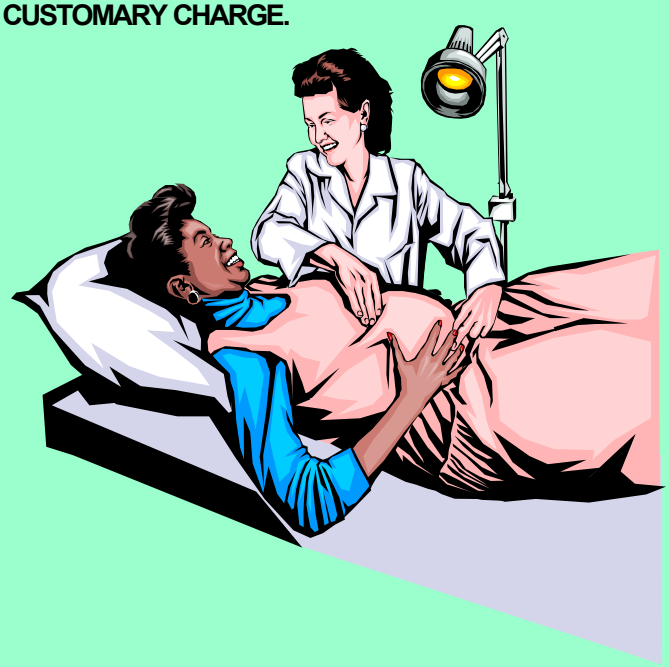
If an inpatient bill is received before emergency room outpatient bill:

- ♦ An outpatient claim within 24 hours of an inpatient admission will be denied. Hospital will need to resubmit an adjusted inpatient bill to include the emergency room service charges along with the inpatient charges.

See claim example.

.

***** **PLEASE NOTE THAT THE CHARGES ON THE CLAIM MUST BE THE USUAL AND CUSTOMARY CHARGE.**



800-111-222
USA HOSPITAL
999 PARKVIEW AVE
ANYTOWN, KY 40001

1

2

3 PATIENT CONTROL NO.: 234GTA567

4 TYPE OF BILL: 111

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	9/1/02	9/4/02	3				

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
			9/1/02	12	1			30		C1							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A / B / C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
110	ROOM AND BOARD			3	$1,000		
250	PHARMACY				$100.00		
270	SUPPLIES				$100.00		
450	EMERGENCY ROOM	99284			$230.00		
001	TOTAL CHARGE				$1,430		

50 PAYER	51 PROVIDER NO.	52 REL. ASG. INFO BEN	53	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
KY MEDICAID	01223377					

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Nora Ward		4013446688		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
44444444			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
675	3910								675		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS.ID: 56732 Juanita Wolf

83 OTHER PHYS. ID
A

OTHER PHYS. ID
B

84 REMARKS

85 PROVIDER REPRESENTATIVE: **Hand Written Signature** X

86 DATE: 9/5/02

UB-92 HCFA-1450 OCR/ORIGINAL

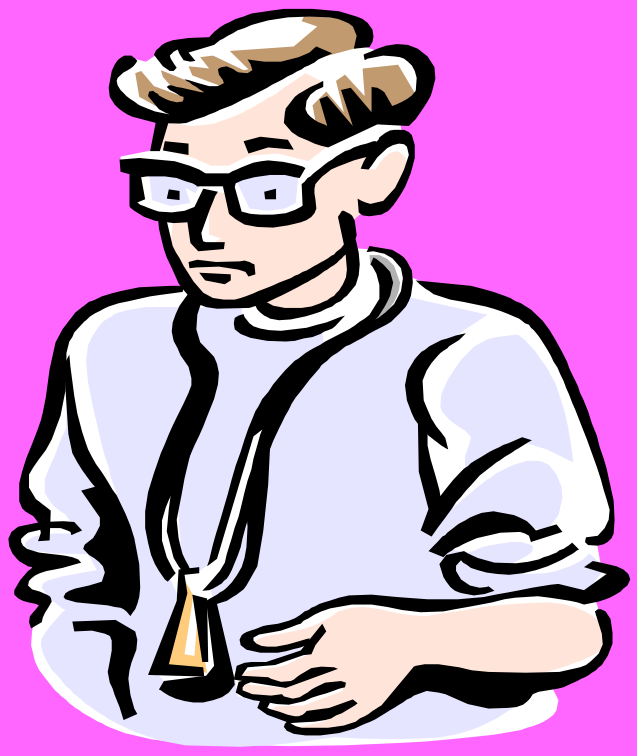
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF..

CLAIM EXAMPLE 4

BILLING PROFESSIONAL FEES ON HCFA 1500

Effective September 1, 2002 all professional fees are to be billed on a HCFA 1500 if they incur in the Emergency Room. See claim example.

******* PLEASE NOTE THAT THE CHARGES ON THE CLAIM MUST BE THE USUAL AND CUSTOMARY CHARGE.**



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK (SSN)	OTHER (ID)
LUNG	X					

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Flowers, Irma E.

3. PATIENT'S BIRTH DATE MM DD YY **SEX** M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
IF APPLICABLE

11. INSURED'S POLICY GROUP OR FECA NUMBER
ENTER ONLY IF OTHER INS. PAID

a. OTHER INSURED'S POLICY OR GROUP NUMBER
4050000000

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY **SEX** M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY **SEX** M F

b. AUTO ACCIDENT? YES NO **PLACE (State)**

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
ENTER ONLY IF OTHER INS. PAID

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO
If yes, return to and complete item 9 a - d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY **FROM** — MM DD YY **TO**

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SEVICES MM DD YY **FROM** — MM DD YY **TO**

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO **$ CHARGES**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. 474.1
2. V20.2
3.
4.

22. MEDICAID RESUBMISSION CODE | **ORIGINAL REF. NO.**

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE
09 01 02		23		99283		1	150.00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.
May use up to 20 digits

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE $ 150 00

29. AMOUNT PAID $ *Other ins. payment*

30. BALANCE DUE $ *If applicable*

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse)
Hand Written Signature
SIGNED DATE 9/4/02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
(If applicable) General Hospital
555 Hospital Drive
Frankfort, KY 40601

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE#
(502) 555-8888
Doug Rose, MD
1000 Medical Drive
Frankfort, KY 40601
PIN# 64000000 GRP# If Applicable

READING YOUR REMITTANCE ADVICE

RA NUMBER: 009257

CLAIM TYPE: OUTPATIENT SERVICES

PROVIDER NAME: USA HOSPITAL
GENERAL HOSPITAL
PROVIDER NUMBER: 01223377

* P A I D C L A I M S *

INVOICE NUMBER	RECIPIENT NAME	IDENTIFICATION NUMBER	TCN	CLAIM SERVICE DATES FROM	THRU	BILLED CHARGES	FLAT RATE	AMOUNT FROM OTHER SRCS	CLAIM PAID AMOUNT	EOB
234GTa567	WARD N	4013446688	30207101700070000	09/01/2002	09/01/2002	1,470.00	570.00	0.00	570.00	365
01 PS: 22	REV/PROC: 350/	QTY: 1		09/01/2002	09/01/2002	500.00	500.00		500.00	
02 PS: 22	REV/PROC: 450/99281	QTY: 1		09/01/2002	09/01/2002	70.00	70.00		70.00	
03 PS: 22	REV/PROC: 480/	QTY: 1		09/01/2002	09/01/2002	900.00	00.00		00.00	

CLAIMS PAID ON THIS RA: 01 TOTAL BILLED: 1,470.00 TOTAL PAID: 570.00

BLANK FORMS

UNISYS

Unisys Corporation
Attention: TPL Unit
P.O. Box 2107
Frankfort, KY 40602

THIRD PARTY LIABILITY LEAD FORM

Provider Name: _____ Provider #: _____

Recipient Name: _____ Recipient #: _____

Address: _____ Date of Birth: _____

From Date of Service: _____ To Date of Service: _____

Date of Admission: _____ Date of Discharge: _____

Insurance Carrier Name: _____

Address: _____

Policy Number: _____ Start Date: _____ End Date: _____

Date Claim was Filed with Insurance Carrier: _____

Please check the one that applies:

_____ No Response in Over 120 Days

_____ Policy Termination Date: _____

_____ Other: Please explain in the space provided below

_____

_____

_____

_____

Contact Name: _____ Contact Telephone #: _____

Signature: _____ Date: _____

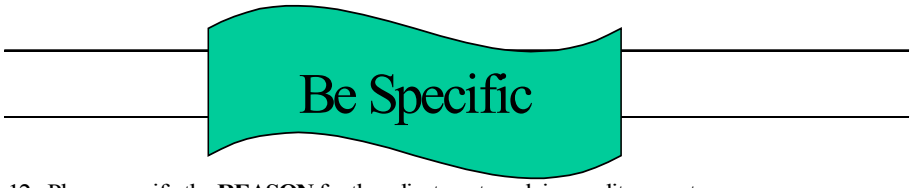
ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: UNISYS CORPORATION
P.O. BOX 2108
FRANKFORT, KENTUCKY 40602
502-226-1140
ATTN: FINANCIAL SERVICES

NOTE: A claim credit voids the claim TCN from the system -- a "new day" claim may be submitted, if necessary. This form will be returned to you if the required information and documentation for processing are not present. Please attach a corrected claim and remittance advice to adjust a claim.

<table>
<tr><td colspan="2">CHECK APPROPRIATE BOX:
CLAIM ADJUSTMENT ☐ CLAIM CREDIT ☐</td><td colspan="2">1. Original Transaction Control Number (TCN)</td></tr>
<tr><td colspan="2">2. Recipient Name</td><td colspan="2">3. Recipient Medicaid Number</td></tr>
<tr><td rowspan="2">4. Provider Name and Address</td><td>5. Provider Number</td><td>6. From Date of Service</td><td>7. To Date of Service</td></tr>
<tr><td>8. Original Billed Amount</td><td>9. Original Paid Amount</td><td>10. Remittance Advice Date</td></tr>
</table>

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.



12. Please specify the **REASON** for the adjustment or claim credit request.

13. Signature _____ 14. Date _____

UNISYS

Mail To: *Unisys Corporation*
P.O. Box 2108
Frank[illegible]08
AT[illegible]

YOUR CHECK NUMBER

YOUR CHECK AMOUNT

[illegible]OCUMENTATION

1. Check Number	**2. Check Amount**
3. Provider Name/Number/Address	**4. Recipient Name**
	5. Recipient Number

6. From Date of Service	**7. To Date of Service**	**8. RA Date**

9. Transaction Control Number (If several TCNs, attach RAs)

Research for Refund: (Check appropriate blank)

_____ **a.** **Payment from other source - Check the category and list name** ***(attach copy of EOB)***
- ____ **Health Insurance**
- ____ **Auto Insurance**
- ____ **Medicare Paid**
- ____ **Other**

_____ **b.** **Billed in error**

_____ **c.** **Duplicate payment (attach a copy of both RAs)**
If RAs are paid to two different providers, specify to which provider number the check is to be applied.

_____ **d.** **Processing error OR overpayment (explain why)**

_____ **e.** **Paid to wrong provider**

_____ **f.** **Money has been requested - date of the letter** ____
(attach a copy of letter requesting money)

_____ **g.** **Other** _____

Contact Name _____ **Phone** _____

KENTUCKY MEDICAID PROVIDER REPRESENTATIVES

VICKY HICKS 502-226-1844	DONNA SIMS 502-696-1835		STAYCE TOWLES 502-696-1831	
ASSIGNED COUNTIES	**ASSIGNED COUNTIES**		**ASSIGNED COUNTIES**	
BOONE	ADAIR	LEWIS	ALLEN	MCCRACKEN
BRECKINRIDGE	ANDERSON	LINCOLN	BALLARD	MCCREARY
CAMPBELL	BATH	MADISON	BARREN	METCALFE
CARROLL	BOURBON	MARION	BELL	MONROE
DAVIESS	BOYD	MASON	BREATHITT	MUHLENBERG
GALLATIN	BOYLE	MENIFEE	CALDWELL	PERRY
HANCOCK	BRACKEN	MERCER	CALLOWAY	PIKE
JEFFERSON	BULLITT	MONTGOMERY	CARLISLE	TODD
KENTON	BUTLER	MORGAN	CHRISTIAN	TRIGG
MCLEAN	CARTER	NELSON	CRITTENDEN	UNION
MEADE	CASEY	NICHOLAS	CLAY	WARREN
OLDHAM	CLARK	OHIO	CLINTON	WAYNE
TRIMBLE	ELLIOTT	OWEN	CUMBERLAND	WEBSTER
	ESTILL	OWSLEY	EDMONDSON	WHITLEY
	FAYETTE	PENDELSON	FLOYD	SIMPSON
	FLEMING	POWELL	FULTON	
	FRANKLIN	PULASKI	GRAVES	
	GARRARD	ROBERTSON	HARLAN	
	GRANT	ROCKCASTLE	JOHNSON	
	GRAYSON	ROWAN	KNOT	
	GREEN	RUSSELL	KNOX	
	GREENUP	SCOTT	HENDERSON	
	HARDIN	SHELBY	HICKMAN	
	HARRISON	SPENCER	HOPKINS	
	HART	TAYLOR	LESLIE	
	HENRY	WASHINGTON	LETCHER	
	JACKSON	WOLFE	LIVINGSTON	
	JESSAMINE	WOODFORD	LOGAN	
	LARUE		LYON	
	LAUREL		MARSHALL	
	LAWRENCE		MAGOFFIN	
	LEE		MARTIN	

BETTY CRABB PROVIDER FIELD/ENROLLMENT REPRESENTATIVE 502-696-1833
PROVIDER RELATIONS 1-800-807-1232

A COPY OF THE NEW BILLING INSTRUCTIONS WILL BE AVAILABLE AT A LATER DATE.

YOU MAY OBTAIN A COPY BY CALLING

PROVIDER ENROLLMENT

1-877-838-5085

PROVIDER RELATIONS

1-800-807-1232

YOU MAY ALSO VISIT THE FOLLOWING WEBSITE AND DOWNLOAD

http://chs.state.ky.us/dms